



General Assembly

February Session, 2008

Raised Bill No. 5158

LCO No. 511

00511_____INS

Referred to Committee on Insurance and Real Estate

Introduced by:
(INS)

AN ACT MAKING CHANGES TO THE INSURANCE STATUTES.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. Section 38a-85 of the general statutes is repealed and the
2 following is substituted in lieu thereof (*Effective October 1, 2008*):

3 (a) Credit for reinsurance shall be allowed a domestic ceding insurer
4 as either an asset or a deduction from liability on account of
5 reinsurance ceded only when the reinsurer meets the requirements of
6 subsection (b), (c), (d), (e) or (f) of this section. If credit is allowed on
7 the basis of meeting the requirements of subsection (d) or (e) of this
8 section, the requirements of subsection (g) of this section shall also be
9 met.

10 (b) Credit shall be allowed when the reinsurance is ceded to an
11 assuming insurer which is licensed to transact insurance or
12 reinsurance in this state.

13 (c) (1) Credit shall be allowed when the reinsurance is ceded to an
14 assuming insurer which is accredited as a reinsurer in this state. No
15 credit shall be allowed a domestic ceding insurer, if the assuming

16 insurers' accreditation has been revoked by the commissioner after
17 notice and hearing. An accredited reinsurer is one which [(1)] (A) files
18 with the commissioner evidence of its submission to this state's
19 jurisdiction, [(2)] (B) submits to this state's authority to examine its
20 books and records, [(3)] (C) is licensed to transact insurance or
21 reinsurance in at least one state, or in the case of a United States branch
22 of an alien assuming insurer is entered through and licensed to
23 transact insurance or reinsurance in at least one state, and [(4)] (D) files
24 annually with the commissioner a copy of its annual statement filed
25 with the insurance department of its state of domicile and a copy of its
26 most recent audited financial statement, and either [(A)] (i) maintains a
27 surplus as regards policyholders in an amount which is not less than
28 twenty million dollars and whose accreditation has not been denied by
29 the commissioner within ninety days of its submission, or [(B)] (ii)
30 maintains a surplus as regards policyholders in an amount less than
31 twenty million dollars and whose accreditation has been approved by
32 the commissioner.

33 (2) Each accredited reinsurer doing business in this state shall,
34 annually, on or before the first day of March, submit to the
35 commissioner, by electronically filing with the National Association of
36 Insurance Commissioners, a true and complete report, signed and
37 sworn to by its president or a vice president, and secretary or an
38 assistant secretary, of its financial condition on the thirty-first day of
39 December next preceding, prepared in accordance with the National
40 Association of Insurance Commissioners annual statement instructions
41 handbook and following those accounting procedures and practices
42 prescribed by the National Association of Insurance Commissioners
43 accounting practices and procedures manual, subject to any deviations
44 in form and detail as may be prescribed by the commissioner. An
45 electronically filed report in accordance with section 38a-53a that is
46 timely submitted to the National Association of Insurance
47 Commissioners is deemed to have been submitted to the commissioner
48 in accordance with this subdivision.

49 (d) Credit shall be allowed when the reinsurance is ceded to an
50 assuming insurer which is domiciled and licensed in, or in the case of a
51 United States branch of an alien assuming insurer is entered through, a
52 state which employs standards regarding credit for reinsurance
53 substantially similar to those applicable in this state and the assuming
54 insurer or United States branch of an alien assuming insurer (1)
55 maintains a surplus as regards policyholders in an amount not less
56 than twenty million dollars and (2) submits to the authority of this
57 state to examine its books and records. The requirement of subdivision
58 (1) of this subsection does not apply to reinsurance ceded and assumed
59 pursuant to pooling arrangements among insurers in the same holding
60 company system.

61 (e) (1) Credit shall be allowed when the reinsurance is ceded to an
62 assuming insurer which maintains a trust fund in a qualified United
63 States financial institution, as defined in subsection (b) of section 38a-
64 87, for the payment of the valid claims of its United States
65 policyholders and ceding insurers, their assigns and successors in
66 interest. The assuming insurer shall report annually to the
67 commissioner information substantially the same as that required to be
68 reported on in the National Association of Insurance Commissioners'
69 Annual Statement form by licensed insurers to enable the
70 commissioner to determine the sufficiency of the trust fund. In the case
71 of a single assuming insurer, the trust shall consist of a trustee'd
72 account representing the assuming insurer's liabilities attributable to
73 business written in the United States and, in addition, the assuming
74 insurer shall maintain a trustee'd surplus of not less than twenty
75 million dollars. In the case of a group including incorporated and
76 individual unincorporated underwriters, the trust shall consist of a
77 trustee'd account representing the group's liabilities attributable to
78 business written in the United States and, in addition, the group shall
79 maintain a trustee'd surplus of which one hundred million dollars shall
80 be held jointly for the benefit of United States ceding insurers of any
81 member of the group; the incorporated members of the group shall not
82 be engaged in any business other than underwriting as a member of

83 the group and shall be subject to the same level of solvency regulation
84 and control by the group's domiciliary regulator as are the
85 unincorporated members; and the group shall make available to the
86 commissioner an annual certification of the solvency of each
87 underwriter by the group's domiciliary regulator and its independent
88 public accountants.

89 (2) Such trust shall be established in a form approved by the
90 commissioner. The trust instrument shall provide that contested claims
91 shall be valid and enforceable upon the final order of any court of
92 competent jurisdiction in the United States. The trust shall vest legal
93 title to its assets in the trustees of the trust for its United States
94 policyholders and ceding insurers, their assigns and successors in
95 interest. The trust and the assuming insurer shall be subject to
96 examination as determined by the commissioner. The trust described
97 herein must remain in effect for as long as the assuming insurer shall
98 have outstanding obligations due under the reinsurance agreements
99 subject to the trust.

100 (3) No later than the first day of March of each year the trustees of
101 the trust shall report to the commissioner in writing setting forth the
102 balance of the trust and listing the trust's investments at the end of the
103 preceding year and shall certify the date of termination of the trust, if
104 so planned, or certify that the trust shall not expire prior to the next
105 following December thirty-first.

106 (4) Each assuming insurance company shall, on or before the first
107 day of March, submit to the commissioner, and electronically to the
108 National Association of Insurance Commissioners, a true and complete
109 report, signed and sworn to by its president or a vice president, and
110 secretary or an assistant secretary, of its financial condition of the trust
111 on the thirty-first day of December next preceding, prepared in
112 accordance with the National Association of Insurance Commissioners
113 annual statement instructions handbook and following those
114 accounting procedures and practices prescribed by the National

115 Association of Insurance Commissioners accounting practices and
116 procedures manual, subject to any deviations in form and detail as
117 may be prescribed by the commissioner. An electronically filed report
118 in accordance with section 38a-53a that is timely submitted to the
119 National Association of Insurance Commissioners does not exempt an
120 assuming insurance company from timely filing a true and complete
121 paper copy with the commissioner.

122 (f) Credit shall be allowed when the reinsurance is ceded to an
123 assuming insurer not meeting the requirements of subsection (b), (c),
124 (d) or (e) of this section but only with respect to the insurance of risks
125 located in jurisdictions where such reinsurance is required by
126 applicable law or regulation of that jurisdiction.

127 (g) If the assuming insurer is not licensed or accredited to transact
128 insurance or reinsurance in this state, the credit permitted by
129 subsections (d) and (e) of this section shall not be allowed unless the
130 assuming insurer agrees (1) that in the event of the failure of the
131 assuming insurer to perform its obligations under the terms of the
132 reinsurance agreement, the assuming insurer, at the request of the
133 ceding insurer, shall (A) submit to the jurisdiction of any court of
134 competent jurisdiction in any state of the United States, (B) comply
135 with all requirements necessary to give such court jurisdiction and (C)
136 abide by the final decision of such court or any appellate court in the
137 event of an appeal, and (2) to designate the commissioner or a
138 designated attorney as its true and lawful attorney upon whom may be
139 served any lawful process in any action, suit or proceeding instituted
140 by or on behalf of the ceding company. This provision is not intended
141 to conflict with or override the obligation of the parties to a
142 reinsurance agreement to arbitrate their disputes, if such an obligation
143 is created in the agreement.

144 Sec. 2. Subparagraph (B) of subdivision (2) of subsection (a) of
145 section 38a-92m of the general statutes is repealed and the following is
146 substituted in lieu thereof (*Effective October 1, 2008*):

147 (B) An insurer licensed in this state to transact surety insurance or
 148 reinsurance, but not financial guaranty insurance pursuant to sections
 149 38a-92 to 38a-92n, inclusive, or accredited as a reinsurer in this state as
 150 provided in subsection (c) (1) of section 38a-85, as amended by this act,
 151 if the insurer or reinsurer meets all of the following criteria: (i) Has and
 152 maintains combined capital and surplus of at least fifty million dollars;
 153 (ii) establishes and maintains the reserves required in section 38a-92c,
 154 except that if the reinsurance agreement is nonproportional, the
 155 contribution to the contingency reserve shall be equal to fifty per cent
 156 of the quarterly written insurance premium; (iii) complies with the
 157 provisions of subsection (b) of section 38a-92i, except that its maximum
 158 aggregate assumed total net liability shall be one-half that permitted
 159 for a financial guaranty insurance corporation. For the purpose of
 160 determining compliance, the reinsurer, unless at the time of cession
 161 and thereafter it is rated in one of the two top generic rating
 162 classifications by a securities rating agency acceptable to the
 163 commissioner, shall be limited to using ten per cent of its capital and
 164 surplus in making this calculation; (iv) complies with the provisions of
 165 section 38a-92j; and (v) assumes, together with all other reinsurers
 166 subject to this subparagraph, less than fifty per cent of the ceding
 167 insurer's total liability after deducting any reinsurance ceded to any
 168 insurers pursuant to subparagraph (A) of this subdivision.

169 Sec. 3. Subsection (a) of section 38a-53 of the 2008 supplement to the
 170 general statutes is repealed and the following is substituted in lieu
 171 thereof (*Effective October 1, 2008*):

172 (a) (1) Each domestic insurance company or health care center shall,
 173 annually, on or before the first day of March, submit to the
 174 commissioner, and electronically to the National Association of
 175 Insurance Commissioners, a true and complete report, signed and
 176 sworn to by its president or a vice president, and secretary or an
 177 assistant secretary, of its financial condition on the thirty-first day of
 178 December next preceding, prepared in accordance with the National
 179 Association of Insurance Commissioners annual statement instructions

180 handbook and following those accounting procedures and practices
181 prescribed by the National Association of Insurance Commissioners
182 accounting practices and procedures manual, subject to any deviations
183 in form and detail as may be prescribed by the commissioner. An
184 electronically filed report in accordance with section 38a-53a that is
185 timely submitted to the National Association of Insurance
186 Commissioners does not exempt a domestic insurance company or
187 health care center from timely filing a true and complete paper copy
188 with the commissioner.

189 (2) Each accredited reinsurer, as defined in subsection (c) of section
190 38a-85, as amended by this act, and assuming insurance company, as
191 provided in section 38a-85, as amended by this act, shall file an annual
192 report in accordance with the provisions of section 38a-85, as amended
193 by this act.

194 Sec. 4. Section 38a-253 of the general statutes is repealed and the
195 following is substituted in lieu thereof (*Effective October 1, 2008*):

196 (a) Any risk retention group not domiciled in this state [which] that
197 is doing business in this state shall submit to the Insurance
198 Commissioner: (1) A copy of the group's financial statement submitted
199 to its state of domicile, which shall be certified by an independent
200 public accountant and contain a statement of opinion on loss and loss
201 adjustment expense reserves made by a member of the American
202 Academy of Actuaries or a qualified loss reserve specialist; (2) a copy
203 of each examination of the risk retention group as certified by the
204 commissioner or public official conducting the examination; (3) upon
205 request by the commissioner, a copy of any audit performed with
206 respect to the risk retention group; and (4) such information as may be
207 required to verify that it satisfies the definitional requirements of
208 subdivision (11) of section 38a-250.

209 (b) Each risk retention group doing business in this state shall,
210 annually, on or before the first day of March, submit to the
211 commissioner, by electronically filing with the National Association of

212 Insurance Commissioners, a true and complete report, signed and
 213 sworn to by its president or a vice president, and secretary or an
 214 assistant secretary, of its financial condition on the thirty-first day of
 215 December next preceding, prepared in accordance with the National
 216 Association of Insurance Commissioners annual statement instructions
 217 handbook and following those accounting procedures and practices
 218 prescribed by the National Association of Insurance Commissioners
 219 accounting practices and procedures manual, subject to any deviations
 220 in form and detail as may be prescribed by the commissioner. An
 221 electronically filed report in accordance with section 38a-53a that is
 222 timely submitted to the National Association of Insurance
 223 Commissioners is deemed to have been submitted to the commissioner
 224 in accordance with this subsection.

225 [(b)] (c) Any risk retention group must submit to an examination by
 226 the Insurance Commissioner to determine its financial condition if the
 227 commissioner of the jurisdiction in which the group is chartered has
 228 not initiated an examination or does not initiate an examination within
 229 sixty days after a request by the Insurance Commissioner of this state.
 230 Any such examination shall be coordinated to avoid unjustified
 231 repetition and conducted in an expeditious manner and in accordance
 232 with the National Association of Insurance Commissioners' Examiner
 233 Handbook.

234 Sec. 5. Section 38a-469 of the general statutes is repealed and the
 235 following is substituted in lieu thereof (*Effective October 1, 2008*):

236 As used in this title, unless the context otherwise requires or a
 237 different meaning is specifically prescribed, "health insurance" policy
 238 means insurance providing benefits due to illness or injury, resulting
 239 in loss of life, loss of earnings, or expenses incurred, and includes the
 240 following types of coverage: (1) Basic hospital expense coverage; (2)
 241 basic medical-surgical expense coverage; (3) hospital confinement
 242 indemnity coverage; (4) major medical expense coverage; (5) disability
 243 income protection coverage; (6) accident only coverage; (7) long term

244 care coverage; (8) specified accident coverage; (9) Medicare
245 supplement coverage; (10) limited benefit health coverage; (11)
246 hospital or medical service plan contract; (12) hospital and medical
247 coverage provided to subscribers of a health care center; (13) specified
248 disease coverage; (14) TriCare supplement coverage.

249 Sec. 6. Section 38a-477a of the general statutes is repealed and the
250 following is substituted in lieu thereof (*Effective October 1, 2008*):

251 The Insurance Commissioner shall provide written or electronic
252 notification to each insurance company, fraternal benefit society,
253 hospital service corporation, medical service corporation, health care
254 center or any other entity that delivers or issues for delivery, in this
255 state, any individual or group health insurance plan (1) of any benefits
256 required to be provided in such plan pursuant to this chapter, or of
257 any modification to such benefits on or after October 1, 2006, at least
258 thirty days prior to the date such benefits or modification becomes
259 effective, and (2) instructing such company, society, corporation,
260 center or other entity to submit to the Insurance Commissioner, prior
261 to the date such benefits or modification becomes effective or upon the
262 renewal date of the plan, any necessary policy forms, in accordance
263 with the provisions of section 38a-481 or 38a-513, as applicable, that
264 reflect such benefits or modification.

265 Sec. 7. Subsection (d) of section 38a-478n of the 2008 supplement to
266 the general statutes is repealed and the following is substituted in lieu
267 thereof (*Effective October 1, 2008*):

268 (d) (1) Not later than five business days after receiving a written
269 request from the commissioner, enrollee or any provider acting on
270 behalf of an enrollee with the enrollee's consent, a managed care
271 organization or health insurer whose enrollee is the subject of an
272 appeal shall provide to the commissioner, enrollee or any provider
273 acting on behalf of an enrollee with the enrollee's consent, written
274 verification of whether the enrollee's plan is fully insured, self-funded,
275 or otherwise funded. If the plan is a fully insured plan or a self-insured

276 governmental plan, the managed care organization or health insurer
277 shall send: (A) Written certification to the commissioner or reviewing
278 entity, as determined by the commissioner, that the benefit or service
279 subject to the appeal is a covered benefit or service; (B) a copy of the
280 entire policy or contract between the enrollee and the managed care
281 organization or health insurer, except that with respect to a self-
282 insured governmental plan, (i) the managed care organization or
283 health insurer shall notify the plan sponsor, and (ii) the plan sponsor
284 shall send, or require the managed care organization or health insurer
285 to send, such copy; or (C) written certification that the policy or
286 contract is accessible to the review entity electronically and clear and
287 simple instructions on how to electronically access the policy or
288 contract.

289 (2) Failure of the managed care organization or health insurer to
290 provide information or notify the plan sponsor in accordance with
291 subdivision (1) of this subsection within said five-business-day period
292 [or before the expiration of the sixty-day period for appeals set forth in
293 subdivision (1) of subsection (b) of this section, whichever is later as
294 determined by the commissioner,] shall (A) create a presumption on
295 the review entity, solely for purposes of accepting an appeal and
296 conducting the review pursuant to subdivision (4) of subsection (b) of
297 this section, that the benefit or service is a covered benefit under the
298 applicable policy or contract, except that such presumption shall not be
299 construed as creating or authorizing benefits or services in excess of
300 those that are provided for in the enrollee's policy or contract, and (B)
301 entitle the commissioner to require the managed care organization or
302 health insurer from whom the enrollee is appealing a medical necessity
303 determination to reimburse the department for the expenses related to
304 the appeal, including, but not limited to, expenses incurred by the
305 review entity.

306 Sec. 8. Section 38a-497 of the 2008 supplement to the general
307 statutes, as amended by section 16 of public act 07-185 and sections 64
308 and 69 of public act 07-2 of the June special session, is repealed and the

309 following is substituted in lieu thereof (*Effective January 1, 2009*):

310 Every individual health insurance policy providing coverage of the
311 type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of
312 section 38a-469, as amended by this act, delivered, issued for delivery,
313 amended or renewed in this state on or after January 1, 2009, shall
314 provide that coverage of a child shall terminate no earlier than the
315 policy anniversary date on or after whichever of the following occurs
316 first, the date on which the child: [marries, or] Marries; attains the age
317 of twenty-six [as long as] if the child is a resident of the state except for
318 full-time attendance at an out-of-state accredited institution of higher
319 education; or [resides out of state with a custodial parent pursuant to a
320 child custody determination, as defined in section 46b-115a] attains the
321 age of twenty-six if the child is a dependent of the policyholder.

322 Sec. 9. Section 38a-554 of the 2008 supplement to the general
323 statutes, as amended by section 17 of public act 07-185 and sections 65
324 and 69 of public act 07-2 of the June special session, is repealed and the
325 following is substituted in lieu thereof (*Effective January 1, 2009*):

326 (a) The plan shall be one under which the individuals eligible to be
327 covered include: (1) Each eligible employee; (2) the spouse of each
328 eligible employee, who shall be considered a dependent for the
329 purposes of this section; and (3) dependent unmarried children
330 [residing in the state,] who are under twenty-six years of age.

331 (b) The plan shall provide the option to continue coverage under
332 each of the following circumstances until the individual is eligible for
333 other group insurance, except as provided in subdivisions (3) and (4)
334 of this subsection: (1) Notwithstanding any provision of this section,
335 upon layoff, reduction of hours, leave of absence, or termination of
336 employment, other than as a result of death of the employee or as a
337 result of such employee's "gross misconduct" as that term is used in 29
338 USC 1163(2), continuation of coverage for such employee and such
339 employee's covered dependents for the periods set forth for such event
340 under federal extension requirements established by the federal

341 Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272),
342 as amended from time to time, (COBRA), except that if such reduction
343 of hours, leave of absence or termination of employment results from
344 an employee's eligibility to receive Social Security income,
345 continuation of coverage for such employee and such employee's
346 covered dependents until midnight of the day preceding such person's
347 eligibility for benefits under Title XVIII of the Social Security Act; (2)
348 upon the death of the employee, continuation of coverage for the
349 covered dependents of such employee for the periods set forth for such
350 event under federal extension requirements established by the
351 Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272),
352 as amended from time to time, (COBRA); (3) regardless of the
353 employee's or dependent's eligibility for other group insurance, during
354 an employee's absence due to illness or injury, continuation of
355 coverage for such employee and such employee's covered dependents
356 during continuance of such illness or injury or for up to twelve months
357 from the beginning of such absence; (4) regardless of an individual's
358 eligibility for other group insurance, upon termination of the group
359 plan, coverage for covered individuals who were totally disabled on
360 the date of termination shall be continued without premium payment
361 during the continuance of such disability for a period of twelve
362 calendar months following the calendar month in which the plan was
363 terminated, provided claim is submitted for coverage within one year
364 of the termination of the plan; (5) the coverage of any covered
365 individual shall terminate: (A) As to a child, the plan shall provide the
366 option for said child to continue coverage for the longer of the
367 following periods: (i) At the end of the month following the month in
368 which the child: [~~marries, or~~] Marries; attains the age of twenty-six [,
369 provided] if the child is a resident of the state except for full-time
370 attendance at an out-of-state accredited institution of higher education;
371 or [~~resides out of state with a custodial parent pursuant to a child~~
372 ~~custody determination, as defined in section 46b-115a~~] attains the age
373 of twenty-six if the child is a dependent of the policyholder. If on the
374 date specified for termination of coverage on a child, the child is

375 unmarried and incapable of self-sustaining employment by reason of
376 mental or physical handicap and chiefly dependent upon the
377 employee for support and maintenance, the coverage on such child
378 shall continue while the plan remains in force and the child remains in
379 such condition, provided proof of such handicap is received by the
380 carrier within thirty-one days of the date on which the child's coverage
381 would have terminated in the absence of such incapacity. The carrier
382 may require subsequent proof of the child's continued incapacity and
383 dependency but not more often than once a year thereafter, or (ii) for
384 the periods set forth for such child under federal extension
385 requirements established by the Consolidated Omnibus Budget
386 Reconciliation Act of 1985 (P.L. 99-272), as amended from time to time,
387 (COBRA); (B) as to the employee's spouse, at the end of the month
388 following the month in which a divorce, court-ordered annulment or
389 legal separation is obtained, whichever is earlier, except that the plan
390 shall provide the option for said spouse to continue coverage for the
391 periods set forth for such events under federal extension requirements
392 established by the Consolidated Omnibus Budget Reconciliation Act of
393 1985 (P.L. 99-272), as amended from time to time, (COBRA); and (C) as
394 to the employee or dependent who is sixty-five years of age or older,
395 as of midnight of the day preceding such person's eligibility for
396 benefits under Title XVIII of the federal Social Security Act; (6) as to
397 any other event listed as a "qualifying event" in 29 USC 1163, as
398 amended from time to time, continuation of coverage for such periods
399 set forth for such event in 29 USC 1162, as amended from time to time,
400 provided such plan may require the individual whose coverage is to be
401 continued to pay up to the percentage of the applicable premium as
402 specified for such event in 29 USC 1162, as amended from time to time.
403 Any continuation of coverage required by this section except
404 subdivision (4) or (6) of this subsection may be subject to the
405 requirement, on the part of the individual whose coverage is to be
406 continued, that such individual contribute that portion of the premium
407 the individual would have been required to contribute had the
408 employee remained an active covered employee, except that the

409 individual may be required to pay up to one hundred two per cent of
410 the entire premium at the group rate if coverage is continued in
411 accordance with subdivision (1), (2) or (5) of this subsection. The
412 employer shall not be legally obligated by sections 38a-505, 38a-546
413 and 38a-551 to 38a-559, inclusive, to pay such premium if not paid
414 timely by the employee.

415 Sec. 10. Subsection (e) of section 38a-702e of the general statutes is
416 repealed and the following is substituted in lieu thereof (*Effective from*
417 *passage*):

418 (e) Each applicant for an insurance producer license shall, before
419 being admitted to an examination under subsection (a) of this section,
420 prove to the satisfaction of the commissioner that such applicant meets
421 one of the following prerequisites: (1) Successful completion of a
422 course approved by the commissioner requiring not less than [forty]
423 twenty hours for each line of insurance for which the applicant is
424 applying to be licensed; or (2) equivalent experience or training as
425 determined by the commissioner.

426 Sec. 11. Section 38a-860 of the general statutes is repealed and the
427 following is substituted in lieu thereof (*Effective October 1, 2008*):

428 (a) Sections 38a-858 to 38a-875, inclusive, as amended by this act,
429 shall provide coverage for the policies and contracts specified in
430 subsection (f) of this section: (1) To any person, except for a
431 nonresident certificate holder under a group policy or contract, who is
432 the beneficiary, assignee or payee of the person covered under
433 subdivision (2) of this subsection, regardless of where the person
434 resides, and (2) any person who is the owner of, or certificate holder
435 under, such policy or contract and in each case who (A) is a resident,
436 or (B) is not a resident, provided (i) the insurer that issued such policy
437 or contract is domiciled in this state, (ii) the state in which the person
438 resides has an association similar to the association created by this
439 section and sections 38a-837, 38a-838, 38a-845, 38a-853, 38a-862, 38a-
440 863, 38a-865 and 38a-866, and (iii) the person is not eligible for

441 coverage by an association in any other state because the insurer was
442 not licensed in the state at the time specified in the state's guaranty
443 association law.

444 (b) For unallocated annuity contracts specified in subsection (f) of
445 this section, subdivisions (1) and (2) of subsection (a) of this section
446 shall not apply, and except as provided in subsections (d) and (e) of
447 this section, sections 38a-858 to 38a-875, inclusive, as amended by this
448 act, shall apply to: (1) Any person who is the owner of the unallocated
449 annuity contract if the contract is issued to, or in connection with, a
450 specific benefit plan whose plan sponsor has its principal place of
451 business in this state; and (2) any person who is the owner of an
452 unallocated annuity contract issued to, or in connection with,
453 government lotteries if the owners are residents.

454 (c) For structured settlement annuities specified in subsection (f) of
455 this section, subdivisions (1) and (2) of subsection (a) of this section
456 shall not apply, and except as provided in subsections (d) and (e) of
457 this section, sections 38a-858 to 38a-875, inclusive, as amended by this
458 act, shall apply to a person who is a payee under a structured
459 settlement annuity, or to a beneficiary of a payee if the payee is
460 deceased, if the payee: (1) Is a resident, regardless of where the
461 contract owner resides, or (2) is not a resident, provided: (A) (i) The
462 contract owner of the structured settlement annuity is a resident, or (ii)
463 the contract owner of the structured settlement annuity is not a
464 resident, but the insurer that issued the structured settlement annuity
465 is domiciled in this state, and the state in which the contract owner
466 resides has an association similar to the association created by sections
467 38a-858 to 38a-875, inclusive; and (B) neither the payee, beneficiary or
468 contract owner is eligible for coverage by the association of the state in
469 which the payee, beneficiary or contract owner resides.

470 (d) Sections 38a-858 to 38a-875, inclusive, as amended by this act,
471 shall not provide coverage to: (1) A person who is a payee or
472 beneficiary of a contract owner resident of this state, if the payee or

473 beneficiary is afforded any coverage by the association of another state;
474 or (2) a person covered under subsection (b) of this section, if any
475 coverage is provided by the association of another state to the person.

476 (e) Sections 38a-858 to 38a-875, inclusive, as amended by this act,
477 shall provide coverage to a person who is a resident and, in special
478 circumstances, to a nonresident. In order to avoid duplicate coverage,
479 if a person who would otherwise receive coverage under sections 38a-
480 858 to 38a-875, inclusive, as amended by this act, is provided coverage
481 under the laws of any other state, the person shall not be provided
482 coverage under sections 38a-858 to 38a-875, inclusive, as amended by
483 this act. In determining the application of the provisions of this
484 subsection in situations where a person could be covered by the
485 association of more than one state, whether as an owner, payee,
486 beneficiary or assignee, sections 38a-858 to 38a-875, inclusive, as
487 amended by this act, shall be construed in conjunction with the laws of
488 other states to result in coverage by only one association.

489 (f) (1) Sections 38a-858 to 38a-875, inclusive, as amended by this act,
490 shall provide coverage to the persons specified in subsections (a) to (d),
491 inclusive, of this section for direct, nongroup life, health or annuity
492 policies or contracts and supplemental contracts to such policies or
493 contracts, for certificates under direct group policies and contracts, and
494 for unallocated annuity contracts issued by member insurers, except as
495 limited by said sections. Annuity contracts and certificates under
496 group annuity contracts include, but are not limited to, guaranteed
497 investment contracts, deposit administration contracts, unallocated
498 funding agreements, allocated funding agreements, structured
499 settlement annuities, annuities issued to or in connection with
500 government lotteries and any immediate or deferred annuity contracts.
501 (2) Said sections 38a-858 to 38a-875, inclusive, as amended by this act,
502 shall not provide coverage for: (A) Any portion of a policy or contract
503 not guaranteed by the insurer, or under which the risk is borne by the
504 policy or contract holder; (B) any policy or contract of reinsurance,
505 unless assumption certificates have been issued; (C) any portion of a

506 policy or contract to the extent that the rate of interest on which it is
507 based or the interest rate, crediting rate or similar factor determined by
508 use of an index or other external reference stated in the policy or
509 contract employed in calculating returns or changes in value (i)
510 averaged over the period of four years prior to the date on which the
511 member insurer becomes an impaired or insolvent insurer under
512 sections 38a-858 to 38a-875, inclusive, as amended by this act, exceeds
513 the rate of interest determined by subtracting two percentage points
514 from Moody's corporate bond yield average averaged for that same
515 four-year period or for such lesser period if the policy or contract was
516 issued less than four years before the member insurer becomes an
517 impaired or insolvent insurer under sections 38a-858 to 38a-875,
518 inclusive, as amended by this act, whichever is earlier; and (ii) on and
519 after the date on which the member insurer becomes an impaired or
520 insolvent insurer under sections 38a-858 to 38a-875, inclusive, as
521 amended by this act, whichever is earlier, exceeds the rate of interest
522 determined by subtracting three percentage points from Moody's
523 corporate bond yield average as most recently available; (D) any plan
524 or program of an employer, association or similar entity to provide life,
525 health or annuity benefits to its employees or members to the extent
526 that such plan or program is self-funded or uninsured, including, but
527 not limited to, benefits payable by an employer, association or similar
528 entity under (i) a multiple employer welfare arrangement as defined in
529 Section 514 of the federal Employee Retirement Income Security Act of
530 1974, as amended from time to time; (ii) a minimum premium group
531 insurance plan; or (iii) [a stop-loss group insurance plan; or (iv)] an
532 administrative services only contract; (E) any stop-loss or excess loss
533 insurance policy or contract providing for the indemnification of or
534 payment to a policy owner, a contract owner, a plan or another person
535 obligated to pay life, health or annuity benefits; (F) any portion of a
536 policy or contract to the extent that it provides dividends, experience
537 rating credits, voting rights or provides that any fees or allowances be
538 paid to any person, including, but not limited to, the policy or contract
539 holder, in connection with the service to or administration of such

540 policy or contract; [(F)] (G) any policy or contract issued in this state by
541 a member insurer at a time when it was not licensed or did not have a
542 certificate of authority to issue such policy or contract in this state;
543 [(G)] (H) any unallocated annuity contract issued to an employee
544 benefit plan protected under the federal Pension Benefit Guaranty
545 Corporation, regardless of whether the federal Pension Benefit
546 Guaranty Corporation has yet become liable to make any payments
547 with respect to the benefit plan; [(H)] (I) any portion of an unallocated
548 annuity contract that is not issued to, or in connection with a specific
549 employee, union or association of natural persons benefit plan or a
550 government lottery; [(I)] (J) any subscriber contract issued by a health
551 care center; [(J)] (K) a contractual agreement that establishes the
552 insurer's obligation by reference to a portfolio of assets that is not
553 owned or possessed by the insurance company; [(K)] (L) an obligation
554 that does not arise under the express written terms of the policy or
555 contract issued by the insurer to the contract owner or policy owner,
556 including, but not limited to: (i) A claim based on marketing materials;
557 (ii) a claim based on side letters, riders or other documents that were
558 issued by the insurer without meeting applicable policy form filing or
559 approval requirements; (iii) a misrepresentation of or regarding policy
560 benefits; (iv) an extra-contractual claim; or (v) a claim for penalties or
561 consequential or incidental damages; [(L)] (M) a contractual agreement
562 that establishes the member insurer's obligations to provide a book
563 value accounting guaranty for defined contribution benefit plan
564 participants by reference to a portfolio of assets that is owned by the
565 benefit plan or its trustee, which in each case is not an affiliate of the
566 member insurer; and [(M)] (N) a portion of a policy or contract to the
567 extent it provides for interest or other changes in value to be
568 determined by the use of an index or other external reference stated in
569 the policy or contract, but which have not been credited to the policy
570 or contract, or as to which the policy or contract owner's rights are
571 subject to forfeiture, as of the date the member insurer becomes an
572 impaired or insolvent insurer under sections 38a-858 to 38a-875,
573 inclusive, as amended by this act, whichever is earlier. If a policy's or

574 contract's interest or changes in value are credited less frequently than
575 annually, then for purposes of determining the values that have been
576 credited and are not subject to forfeiture under this subparagraph, the
577 interest or change in value determined by using the procedures
578 defined in the policy or contract shall be credited as if the contractual
579 date of crediting interest or changing values was the date of
580 impairment or insolvency, whichever is earlier, and shall not be subject
581 to forfeiture.

582 (g) The benefits for which the association may become liable shall in
583 no event exceed the lesser of: (1) The contractual obligations for which
584 the insurer is liable or would have been liable if it were not an
585 impaired insurer, or (2) (A) with respect to any one life, regardless of
586 the number of policies or contracts: (i) Five hundred thousand dollars
587 in life insurance death benefits, but no more than five hundred
588 thousand dollars in net cash surrender and net cash withdrawal values
589 for life insurance; (ii) five hundred thousand dollars in health
590 insurance benefits, including, but not limited to, any net cash
591 surrender and net cash withdrawal values; (iii) five hundred thousand
592 dollars in the present value of annuity benefits, including, but not
593 limited to, net cash surrender and net cash withdrawal values; (B) with
594 respect to each individual participating in a governmental retirement
595 plan established under Section 401, 403(b) or 457 of the United States
596 Internal Revenue Code covered by an unallocated annuity contract or
597 the beneficiaries of each such individual if deceased, in the aggregate,
598 five hundred thousand dollars in present value annuity benefits,
599 including, but not limited to, net cash surrender and net cash
600 withdrawal values; (C) with respect to each payee of a structured
601 settlement annuity, or beneficiary or beneficiaries of the payee if
602 deceased, five hundred thousand dollars in present value annuity
603 benefits, in the aggregate, including, but not limited to, net cash
604 surrender and net cash withdrawal values, if any, provided in no event
605 shall the association be liable to expend (i) more than the five hundred
606 thousand dollars in the aggregate with respect to any one individual
607 under subparagraphs (A), (B) and (C) of this subdivision, and (ii) with

608 respect to one owner of multiple nongroup policies of life insurance,
609 whether the policy owner is an individual, firm, corporation or other
610 person, and whether the persons insured are officers, managers,
611 employees or other persons, more than five million dollars in benefits,
612 regardless of the number of policies and contracts held by the owner;
613 (D) with respect to either (i) one contract owner provided coverage
614 under subparagraph (B) of subdivision (2) of subsection (b) of this
615 section, or (ii) one plan sponsor whose plans own directly or in trust
616 one or more unallocated annuity contracts not included in subdivision
617 (2) of subsection (f) of this section, five million dollars in benefits
618 regardless of the number of contracts with respect to the contract
619 owner or plan sponsor, except that in the case where one or more
620 unallocated annuity contracts are covered contracts under sections 38a-
621 858 to 38a-875, inclusive, as amended by this act, and are owned by a
622 trust or other entity for the benefit of two or more plan sponsors,
623 coverage shall be afforded by the association if the largest interest in
624 the trust or entity owning the contract or contracts is held by a plan
625 sponsor whose principal place of business is in this state and in no
626 event shall the association be obligated to cover more than five million
627 dollars in benefits with respect to all such unallocated contracts.

628 (h) The limits set forth in subsection (g) of this section are limits on
629 the benefits for which the association is obligated before taking into
630 account either the association's subrogation and assignment rights or
631 the extent to which those benefits could be provided out of the assets
632 of the impaired or insolvent insurer that are attributable to covered
633 policies. The costs of the association's obligations under sections 38a-
634 858 to 38a-875, inclusive, as amended by this act, may be met by the
635 use of assets attributable to covered policies or reimbursed to the
636 association pursuant to the association's subrogation and assignment
637 rights.

638 (i) In performing its obligation to provide coverage under section
639 38a-865, the association shall not be required to guarantee, assume,
640 reinsure or perform, or cause to be guaranteed, assumed, reinsured or

641 performed, the contractual obligations of the insolvent or impaired
642 insurer under a covered policy or contract that does not materially
643 affect the economic value or economic benefit of the covered policy or
644 contract.

645 Sec. 12. Section 38a-482b of the 2008 supplement to the general
646 statutes is repealed and the following is substituted in lieu thereof
647 (*Effective October 1, 2008*):

648 (a) Each individual health insurance policy, subscriber contract or
649 certificate of coverage delivered or issued for delivery in this state on
650 or after January 1, 2008, that provides limited coverage, and any
651 marketing material, application for coverage and enrollment material
652 relative to such policy, contract or certificate, shall include the
653 following statement printed in capital letters in not less than twelve-
654 point bold face type and located in a conspicuous manner on such
655 document:

656 "THIS LIMITED HEALTH BENEFITS PLAN DOES NOT PROVIDE
657 COMPREHENSIVE MEDICAL COVERAGE. IT IS A BASIC OR
658 LIMITED BENEFITS POLICY AND IS NOT INTENDED TO COVER
659 ALL MEDICAL EXPENSES. THIS PLAN IS NOT DESIGNED TO
660 COVER THE COSTS OF SERIOUS OR CHRONIC ILLNESS. IT
661 CONTAINS SPECIFIC DOLLAR LIMITS THAT WILL BE PAID FOR
662 MEDICAL SERVICES WHICH MAY NOT BE EXCEEDED. IF THE
663 COST OF SERVICES EXCEEDS THOSE LIMITS, THE BENEFICIARY
664 AND NOT THE INSURER IS RESPONSIBLE FOR PAYMENT OF THE
665 EXCESS AMOUNTS. THE SPECIFIC DOLLAR LIMITS ARE AS
666 FOLLOWS: (INSURER TO SPECIFY SUCH AMOUNTS)."

667 (b) For the purposes of this section, "limited coverage" means an
668 insurance policy providing coverage of the type specified in
669 subdivisions (1), (2), (4), (11) and (12) of section 38a-469 that contains
670 an annual maximum benefit of less than one hundred thousand
671 dollars. [or a per service or per condition benefit limit of less than
672 twenty thousand dollars.]

673 Sec. 13. Section 38a-513d of the 2008 supplement to the general
674 statutes is repealed and the following is substituted in lieu thereof
675 (*Effective October 1, 2008*):

676 (a) No insurer, health care center, hospital service corporation,
677 medical service corporation or other entity delivering, issuing for
678 delivery, renewing, continuing or amending any group health
679 insurance policy in this state on or after January 1, 2008, shall deliver
680 or issue for delivery in this state any policy providing limited coverage
681 to any employer as a replacement for a comprehensive health
682 insurance plan for its employees.

683 (b) Each group health insurance policy, subscriber contract or
684 certificate of coverage delivered or issued for delivery in this state on
685 or after January 1, 2008, that provides limited coverage, and any
686 marketing material, application for coverage and enrollment material
687 relative to such policy, contract or certificate, shall include the
688 following statement printed in capital letters in not less than twelve-
689 point bold face type and located in a conspicuous manner on such
690 document:

691 "THIS LIMITED HEALTH BENEFITS PLAN DOES NOT PROVIDE
692 COMPREHENSIVE MEDICAL COVERAGE. IT IS A BASIC OR
693 LIMITED BENEFITS POLICY AND IS NOT INTENDED TO COVER
694 ALL MEDICAL EXPENSES. THIS PLAN IS NOT DESIGNED TO
695 COVER THE COSTS OF SERIOUS OR CHRONIC ILLNESS. IT
696 CONTAINS SPECIFIC DOLLAR LIMITS THAT WILL BE PAID FOR
697 MEDICAL SERVICES WHICH MAY NOT BE EXCEEDED. IF THE
698 COST OF SERVICES EXCEEDS THOSE LIMITS, THE BENEFICIARY
699 AND NOT THE INSURER IS RESPONSIBLE FOR PAYMENT OF THE
700 EXCESS AMOUNTS. THE SPECIFIC DOLLAR LIMITS ARE AS
701 FOLLOWS: (INSURER TO SPECIFY SUCH AMOUNTS)."

702 (c) For the purposes of this section, "limited coverage" means an
703 insurance policy providing coverage of the type specified in
704 subdivisions (1), (2), (4), (11) and (12) of section 38a-469 that contains

705 an annual maximum benefit of less than one hundred thousand
706 dollars. [or a per service or per condition benefit limit of less than
707 twenty thousand dollars.]

708 Sec. 14. Section 38a-432a of the general statutes is repealed and the
709 following is substituted in lieu thereof (*Effective from passage*):

710 The Insurance Commissioner shall adopt regulations, in accordance
711 with chapter 54, to establish (1) standards for the sale or exchange of
712 annuities, as defined in section 38a-1, [of the general statutes,] to
713 [senior] consumers, and (2) procedures for making recommendations
714 to [senior] consumers regarding the sale or exchange of an annuity.
715 [For purposes of said regulations, "senior consumer" means an
716 individual sixty-five years of age or older, except that in the event of a
717 joint purchase by more than one person, the purchaser shall be
718 considered to be a senior consumer if any of the purchasers is sixty-
719 five years of age or older.]

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>October 1, 2008</i>	38a-85
Sec. 2	<i>October 1, 2008</i>	38a-92m(a)(2)(B)
Sec. 3	<i>October 1, 2008</i>	38a-53(a)
Sec. 4	<i>October 1, 2008</i>	38a-253
Sec. 5	<i>October 1, 2008</i>	38a-469
Sec. 6	<i>October 1, 2008</i>	38a-477a
Sec. 7	<i>October 1, 2008</i>	38a-478n(d)
Sec. 8	<i>January 1, 2009</i>	38a-497
Sec. 9	<i>January 1, 2009</i>	38a-554
Sec. 10	<i>from passage</i>	38a-702e(e)
Sec. 11	<i>October 1, 2008</i>	38a-860
Sec. 12	<i>October 1, 2008</i>	38a-482b
Sec. 13	<i>October 1, 2008</i>	38a-513d
Sec. 14	<i>from passage</i>	38a-432a

Statement of Purpose:

To make changes to the insurance statutes.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]